MRI PROCEDURE SCREENING FORM

Date _____
Name _____
Sex _____ Age _____ Physician _____ Patient No. _____
Date of Birth _____ Height _____ Weight _____
Procedure _____ ❑ Outpatient ❑ Inpatient
Diagnosis _____
Clinical History _____
_____
_____

	YES	NO
Have you ever had a surgical procedure or operation of any kind?	❑	❑
If yes, please list all prior surgeries and approximate dates: _____		
Have you ever been injured by any metallic foreign body? (e.g., bullet, BB, shrapnel, etc.)	❑	❑
Please describe: _____		
Have you ever had an injury to the eye involving a metallic object? (e.g., metal slivers, shavings, foreign body, etc.)	❑	❑
Please describe: _____		
Do you have anemia or diseases that affect your blood?	❑	❑
Do you have a history of renal disease, seizures, asthma, or allergic respiratory disease?	❑	❑
Do you have any drug allergies?	❑	❑
If yes, please list: _____		
Have you ever had a reaction to a contrast medium used for MRI or CT?	❑	❑
Are you pregnant or do you suspect that you are pregnant?	❑	❑
Are you breastfeeding?	❑	❑
Last menstrual period: _____ Post-menopausal?	❑	❑
Are you taking oral contraceptives or receiving hormone treatment?	❑	❑

PERTINENT PREVIOUS STUDIES:

	BODY PART	DATE
X-rays		
Computed tomography		
Ultrasound		
Nuclear Medicine		
MRI		

We strongly recommend using the ear plugs or headphones we supply for your MRI examination since some patients may find the noise levels unacceptable and the noise levels may temporarily affect your hearing.

Continued on other side.

THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT.

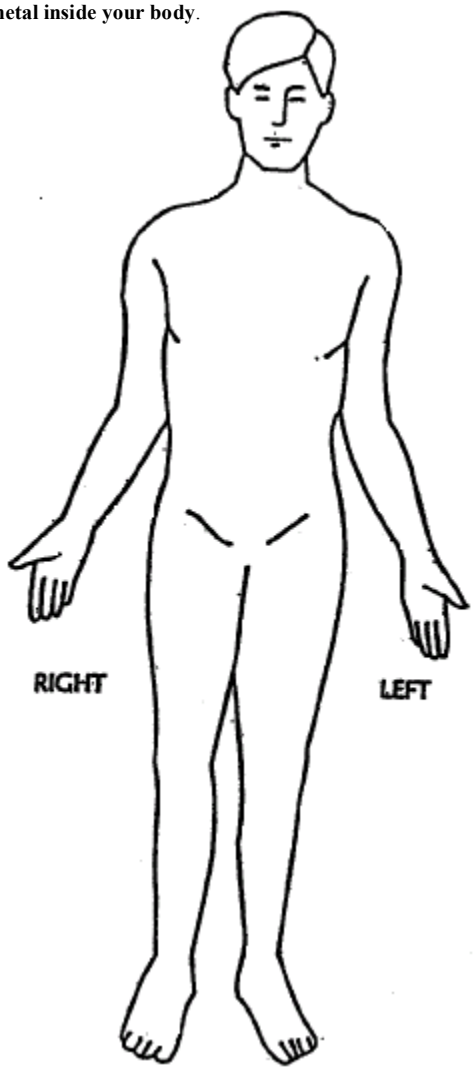
PLEASE INDICATE IF YOU HAVE THE FOLLOWING:

YES NO

- ❑ ❑ Cardiac pacemaker
- ❑ ❑ Aneurysm clip(s)
- ❑ ❑ Implanted cardiac defibrillator
- ❑ ❑ Neurostimulator
- ❑ ❑ Any type of biostimulator
  Type: _____
- ❑ ❑ Any type of internal electrode(s), including
  - Pacing wires
  - Cochlear implant

  Other: _____
- ❑ ❑ Implanted insulin pump
- ❑ ❑ Swan-Ganz catheter
- ❑ ❑ Halo vest or metallic cervical fixation device
- ❑ ❑ Any type of electronic, mechanical, or magnetic implant
  Type: _____
- ❑ ❑ Hearing aid
- ❑ ❑ Any type of intravascular coil, filter, or stent
  (e.g., Gianturcocoil, Gunther IVC filter, Palmaz stent, etc.)
- ❑ ❑ Implanted drug infusion device
- ❑ ❑ Any type of foreign body, shrapnel, or bullet
- ❑ ❑ Heart valve prosthesis
- ❑ ❑ Any type of ear implant
- ❑ ❑ Penile prosthesis
- ❑ ❑ Orbital/eye prosthesis
- ❑ ❑ Any type of implant held in place by a magnet
- ❑ ❑ Any type of surgical clip or staple(s)
- ❑ ❑ Vascular access port
- ❑ ❑ Intraventricular shunt
- ❑ ❑ Artificial limb or joint
- ❑ ❑ Dentures
- ❑ ❑ Diaphragm
- ❑ ❑ IUD
- ❑ ❑ Pessary
- ❑ ❑ Wire mesh
- ❑ ❑ Any implanted orthopedic item(s) (i.e., pins, rods, screws, nails, clip plates, wire, etc.)
  Type: _____
- ❑ ❑ Any other implanted item
  Type: _____
- ❑ ❑ Tattooed eyeliner*

Please mark on this drawing the location of any metal inside your body.



**A small percentage of patients with tattooed eyeliner have experienced transient skin irritation in association with MRI. Therefore you must decide if this slight risk warrants undergoing your examination. You may want to discuss this matter with your referring physician.*

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's signature _____

MD/RN/RT signature _____Date _____

Print MD/RN/RNT name _____